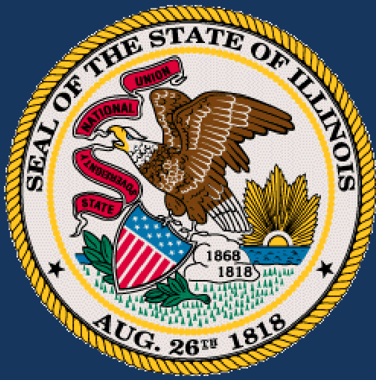


Health and Human
Services Transformation

HHS Transformation: Key takeaways from the first stakeholder working groups

August 2016

Overview of stakeholder working group engagement

- In mid-July, working sessions were held with 4 groups of key stakeholders
  - Consumer advocates
  - Community service providers
  - Medical providers
  - MCOs
- As representatives of the broader Illinois stakeholder community, 70+ key stakeholders attended these meetings and offered defining input into Illinois' behavioral health strategy
- This document outlines some of the key insights from each of these groups
- The next set of working sessions will take place in September

Illinois has identified 6 primary pain points in the behavioral health system (1/2)

Lack of coordination of behavioral health services

- Currently no designated point of accountability for whole-person needs (medical and behavioral health care)
- Services often delivered in silos, resulting in service gaps, particularly during transitions between care settings and during major life changes (such as loss of housing)
- Lack of coordination results in care deficiencies and sub-optimal care allocation

Challenges in identifying and accessing those with the greatest needs

- No evidence-based approach to identify need and target care
- Limited funding for identification and prevention services
- Un-integrated, disparate access points for key subpopulations such as homeless individuals and parolees
- Care tends to be reactive rather than focusing on preventative solutions

Insufficient community behavioral health services capacity

- Limited community capacity prohibits behavioral health services from being provided in the most appropriate, lowest-acuity settings possible
- Capacity limited by the number of providers and by lack of infrastructure, such as outpatient clinics and crisis services
- Community capacity has not yet expanded to meet the needs of an expanded Medicaid population

SOURCE: Recent State experience

Illinois has identified 6 primary pain points in the behavioral health system (2/2)

Limited support services to address "whole-person" needs	▪ Assistance in housing, transport, and job training does not meet current needs ▪ Existing services not optimally coordinated
Duplication and gaps in in behavioral health services across agencies raise costs	▪ Duplication results from a lack of a cross-agency procurement strategy ▪ Gaps result because many programs and services lack a "natural owner" to provide them ▪ Symptom of program-centric (rather than member-centric) orientation of the behavioral health system
Deficiencies in data, analytics, and transparency	▪ Insufficient availability, usability, and integration of data, compromising insights ▪ No single source of truth ▪ Information often not shared across state agencies and providers, making it difficult draw critical insights

SOURCE: Recent State experience

Detail: Emerging workgroup themes on behavioral health system pain points (1/2)

NOT EXHAUSTIVE

Consumer advocates	▪ System fragmentation limits ability to address customers in person-centered manner ▪ Privacy laws inhibit transparent communication between behavioral health and primary care providers ▪ Lack of presumptive eligibility hinders smooth hospital to community transitions ▪ Limited involvement of schools inhibits early identification and care coordination ▪ Limited flexibility and evidence-based models leads to customers being addressed in a “one-size fits all” manner
Community services	▪ Limited behavioral health prevention screenings taking place outside settings of traditional behavioral health service provision reduces potential impact ▪ Regulatory barriers (e.g., restrictive nature of Rule 132 limits flexibility) ▪ Limited prevention services exacerbate dependence on deep-end institutional care and drives growth of health care costs ▪ Current managed care system inhibits flexibility to move to outcomes-based models ▪ Payer reimbursement timelines create difficulties for providers ▪ Limited access to trauma-informed care reduces efficacy of service provision ▪ Complex pre-authorization processes can disrupt care delivery for behavioral health customers ▪ Insufficient data sharing hinders integrated coordination of care

SOURCE: Discussions from HHS Transformation working group session 1

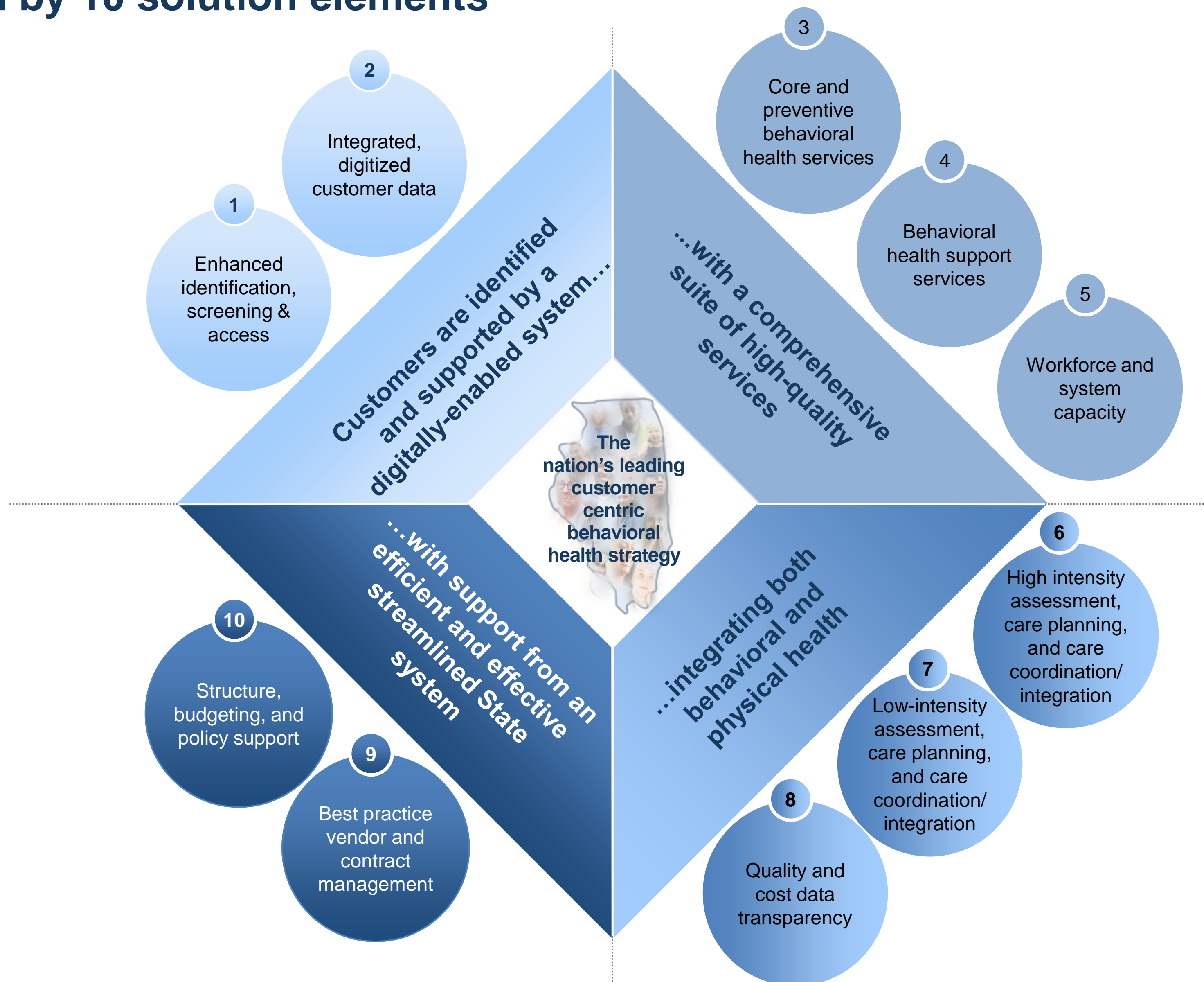
Detail: Emerging workgroup themes on behavioral health system pain points (2/2)

NOT EXHAUSTIVE

Providers	▪ Limited data transparency leads to difficulty identifying customers with greatest needs ▪ Lack of comprehensive view of customers inhibits system-wide care coordination ▪ Insufficient early identification leads to downstreamed entry points into the system e.g., ED or jail ▪ Subscale investment in training programs and incentives deepens workforce gaps ▪ Insufficient links to necessary crisis intervention services e.g., law enforcement crisis response, yields greater utilization of inpatient hospitalizations
MCOs	▪ Limited funding for training programs exacerbates acute mental health workforce gaps ▪ Lack of consistent and comprehensive opportunities to partner with providers in different areas of the State ▪ Insufficient access to complete, transparent data that serves as "single source of truth" limits ability to provide right care at the right time ▪ Limited support for individuals during critical periods inhibits seamless transitions in care

SOURCE: Discussions from HHS Transformation working group session 1

Illinois has created a customer-centric behavioral health strategy under-pinned by 10 solution elements



Detail: Emerging workgroup themes on behavioral health system solutions (1/3)

NOT EXHAUSTIVE

Consumer advocates	▪ Increasing data transparency can unlock efficiencies, improve customer experience, and improve outcomes ▪ Creating incentives to attract behavioral health workforce can enhance access to care provision ▪ Streamlining Rule 132 and authorization processes can allow for a more integrated physical and behavioral health system
Community services	▪ Increasing screening and identification services can reduce deep-end care ▪ Investing in workforce capacity can create a more sustainable behavioral system ▪ Creating more diversified entry points to care can optimize use of upstream behavioral health services ▪ Linkage case management, i.e. “turbo charged services”, can improve key transitions ▪ Funding intensive interventions like First Episode Psychosis on the front-end can improve long-term outcomes ▪ Including the educational system (“front door of behavioral health system for youths”) as a core component of the behavioral health strategy can improve youth outcomes ▪ Implementing active surveillance from local health departments can enhance needs identification

SOURCE: Discussions from HHS Transformation working group session 1

Detail: Emerging workgroup themes on behavioral health system solutions (2/3)

NOT EXHAUSTIVE

Community services (cont.)	▪ Implementing wrap around services for transitioning youth can ease difficult transitions ▪ Providing linkages between prisons, jails, and the health care system before customers leave prison can improve transitional outcomes ▪ Implementing workforce development programs (e.g. student loan forgiveness, grants, EMRs) can incentivize providers to practice in underserved areas
Providers	▪ Taking a multifaceted approach that includes initiatives beyond the 1115 waiver can improve overall transformation ▪ Ensuring adequate rates, investing in training, and streamlining administrative systems can help build behavioral health workforce capacity ▪ Shifting focus of care from inpatient to community care can diminish costs and improve care delivery ▪ Streamlining Rule 132/2060/2090 and MCO authorization processes can diminish significant barriers to integrated care ▪ Investing in community capacity can help ensure a full continuum of behavioral health services ▪ Shifting MCOs from utilization management to care management can improve access to care

SOURCE: Discussions from HHS Transformation working group session 1

Detail: Emerging workgroup themes on behavioral health system solutions (3/3)

NOT EXHAUSTIVE

Providers (cont.)	▪ Transitioning MCOs to pay for outcomes rather than manage risk can lead to more productive provider partnerships and improved outcomes ▪ Ensuring adequate reimbursement for care for youths can help mitigate gap in availability of psychiatrists for children ▪ Increasing access to crisis management resources can reduce inpatient hospitalizations ▪ Increasing array of low intensity and peer support services can provide cost-friendly alternative to deep-end care
MCOs	▪ "Narrowing the front door" to institutional settings can drastically reduce costs ▪ Increasing workforce initiatives can create more access points to care ▪ Integrating behavioral and physical health care can provide better, "whole-person" care ▪ Implementing first episode psychosis programs can reduce inpatient hospitalizations ▪ Integrating data from schools, local, and state systems in the 360 online view can capture a fuller vision of the consumer ▪ Improving provider access to real time data can allow providers to see when customers are hospitalized and improve transitions ▪ Supporting telehealth programs for both rural and urban populations can improve access for hard to reach populations

SOURCE: Discussions from HHS Transformation working group session 1